

**VALPROIC ACID - valproic acid capsule, liquid filled**

Banner Pharmacaps, Inc

**BOXED WARNING****HEPATOTOXICITY**

**HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONSULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN VALPROIC ACID IS USED IN THIS PATIENT GROUP, IT SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS. THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.**

**TERATOGENICITY**

**VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF VALPROATE IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE WARNINGS, INFORMATION FOR PATIENTS.**

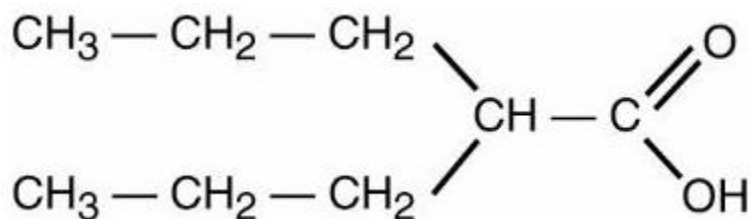
**AN INFORMATION SHEET DESCRIBING THE TERATOGENIC POTENTIAL OF VALPROATE IS AVAILABLE FOR PATIENTS.**

**PANCREATITIS**

**CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See WARNINGS and PRECAUTIONS.)**

**DESCRIPTION**

Valproic acid is a carboxylic acid designated as 2-propylpentanoic acid. It is also known as dipropylacetic acid. Valproic acid has the following structure:



Valproic acid (pKa 4.8) has a molecular weight of 144 and occurs as a colorless liquid with a characteristic odor. It is slightly soluble in water (1.3 mg/mL) and very soluble in organic solvents.

Valproic acid is supplied as soft-gelatin capsules for oral administration. Each capsule contains 250 mg valproic acid

**Inactive Ingredients**

Corn oil, FD&C Blue No. 1, gelatin, glycerin, purified water and titanium dioxide.

## CLINICAL PHARMACOLOGY

### Pharmacodynamics

Valproic acid dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its antiepileptic effects have not been established. It has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

### Pharmacokinetics

#### Absorption/Bioavailability

Although the rate of valproate ion absorption may vary with the conditions of use (e.g., fasting or postprandial) these differences should be of minor clinical importance under the steady state conditions achieved in chronic use in the treatment of epilepsy.

While the absorption rate from the G.I. tract and fluctuation in valproate plasma concentrations vary with dosing regimen and formulation, the efficacy of valproate as an anticonvulsant in chronic use is unlikely to be affected. Experience employing dosing regimens from once-a-day to four-times-a-day, as well as studies in primate epilepsy models involving constant rate infusion, indicate that total daily systemic bioavailability (extent of absorption) is the primary determinant of seizure control and that differences in the ratios of plasma peak to trough concentrations are inconsequential from a practical clinical standpoint.

Co-administration of oral valproate with food should cause no clinical problems in the management of patients with epilepsy (see **DOSAGE AND ADMINISTRATION**). Nonetheless, any changes in dosage administration, or the addition or discontinuance of concomitant drugs should ordinarily be accompanied by close monitoring of clinical status and valproate plasma concentrations.

#### Distribution

##### *Protein Binding*

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 mcg/mL to 18.5% at 130 mcg/mL. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide). (See **PRECAUTIONS - Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs.)

##### *CNS Distribution*

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

#### Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial  $\beta$ -oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

#### Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m<sup>2</sup> and 11 L/1.73 m<sup>2</sup>, respectively. Mean plasma clearance and volume of distribution for free valproate are 4.6 L/hr/1.73 m<sup>2</sup> and 92 L/1.73 m<sup>2</sup>. Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1000 mg.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn.

#### Special Populations

##### *Effect of Age*

##### Neonates

Children within the first two months of life have a markedly decreased ability to eliminate valproate compared to older children and adults. This is a result of reduced clearance (perhaps due to delay in development of glucuronosyltransferase and other enzyme systems involved in valproate elimination) as well as increased volume of distribution (in part due to decreased plasma protein binding). For example, in one study, the half-life in children under 10 days ranged from 10 to 67 hours compared to a range of 7 to 13 hours in children greater than 2 months.

#### Children

Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults.

#### Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly. (See **DOSAGE AND ADMINISTRATION**).

#### *Effect of Gender*

There are no differences in the body surface area adjusted unbound clearance between males and females ( $4.8 \pm 0.17$  and  $4.7 \pm 0.07$  L/hr per  $1.73 \text{ m}^2$ , respectively).

#### *Effect of Race*

The effects of race on the kinetics of valproate have not been studied.

#### *Effect of Disease*

##### Liver Disease

(See **BOXED WARNING, CONTRAINDICATIONS, and WARNINGS**). Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

##### Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

#### **Plasma Levels and Clinical Effect**

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 mcg/mL to 18.5% at 130 mcg/mL. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

#### Epilepsy

The therapeutic range is commonly considered to be 50 to 100 mcg/mL of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

#### **INDICATIONS AND USAGE**

Valproic acid is indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizures. Valproic acid is indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures, and adjunctively in patients with multiple seizure types which include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

## CONTRAINDICATIONS

VALPROIC ACID SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Valproic acid is contraindicated in patients with known hypersensitivity to the drug.

Valproic acid is contraindicated in patients with known urea cycle disorders (see **WARNINGS**).

## WARNINGS

### Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering valproic acid to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. When valproic acid is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above this age group, experience has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

### Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

### Urea Cycle Disorders (UCD)

Valproic acid is contraindicated in patients with known urea cycle disorders. Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

### Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

## **Thrombocytopenia**

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

## **Usage in Pregnancy**

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

## **HUMAN DATA**

### **Congenital Malformations**

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

### **Neural Tube Defects**

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate. Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

#### Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONSULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURE, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

#### ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding 230 mcg/mL (2.3 times the upper limit of the human therapeutic range) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m<sup>2</sup> basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 mcg/mL or greater (3.4 times the upper limit of the human therapeutic range or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m<sup>2</sup> basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m<sup>2</sup> basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 mcg/mL (2.8 times the upper limit of the human therapeutic range).

#### PRECAUTIONS

##### Hepatic Dysfunction

See **BOXED WARNING, CONTRAINDICATIONS, and WARNINGS**.

##### Pancreatitis

See **BOXED WARNING and WARNINGS**.

##### Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS and WARNINGS - Urea Cycle Disorders and PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**). Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered.

##### Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (see **CONTRAINDICATIONS and WARNINGS - Urea Cycle Disorders and PRECAUTIONS - Hyperammonemia**).

##### General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving valproic acid be monitored for platelet count and coagulation parameters

prior to planned surgery. Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since valproate may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

#### **PRECAUTIONS - Drug Interactions**

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test. There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown. There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

#### **Multi-organ Hypersensitivity Reaction**

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days; range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepato-renal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

#### **Information for Patients**

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS - Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since valproic acid may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), patients should be advised not to engage in hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Since valproic acid has been associated with certain types of birth defects, female patients of child-bearing age considering the use of valproic acid should be advised of the risk and of alternative therapeutic options and to read the **Patient Information Leaflet**, which appears as the last section of the labeling. This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see **PRECAUTIONS - Multi-organ Hypersensitivity Reaction**).

#### **Drug Interactions**

##### **Effects of Co-Administered Drugs on Valproate Clearance**

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450 microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

##### **Drugs for Which a Potentially Important Interaction Has Been Observed**

*Aspirin*

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (n = 6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The  $\beta$ -oxidation pathway consisting of 2-E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Caution should be observed if valproate and aspirin are to be co-administered.

#### *Felbamate*

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (n = 10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 mcg/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 mcg/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

#### *Meropenem*

Subtherapeutic valproic acid levels have been reported when meropenem was co-administered.

#### *Rifampin*

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

#### Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

##### *Antacids*

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titralac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

##### *Chlorpromazine*

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

##### *Haloperidol*

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

##### *Cimetidine and Ranitidine*

Cimetidine and ranitidine do not affect the clearance of valproate.

#### Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydase, and glucuronyltransferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

#### Drugs for Which a Potentially Important Valproate Interaction Has Been Observed

##### *Amitriptyline/Nortriptyline*

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

##### *Carbamazepine/carbamazepine-10,11-Epoxyde*



Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxide (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

#### *Clonazepam*

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

#### *Diazepam*

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n = 6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

#### *Ethosuximide*

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (n = 6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

#### *Lamotrigine*

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

#### *Phenobarbital*

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n = 6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

#### *Phenytoin*

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg) in normal volunteers (n = 7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

#### *Tolbutamide*

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

#### *Topiramate*

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia** and **-Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

#### *Warfarin*

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%.

The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if valproic acid therapy is instituted in patients taking anticoagulants.

#### *Zidovudine*

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

#### Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

##### *Acetaminophen*

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

##### *Clozapine*

In psychotic patients (n = 11), no interaction was observed when valproate was co-administered with clozapine.

##### *Lithium*

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n = 16) had no effect on the steady-state kinetics of lithium.

##### *Lorazepam*

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n = 9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

##### *Oral Contraceptive Steroids*

Administration of a single-dose of ethinylloestradiol (50 mcg)/levonorgestrel (250 mcg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

#### **Carcinogenesis, Mutagenesis, Impairment of Fertility**

##### Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m<sup>2</sup> basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

##### Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

##### Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m<sup>2</sup> basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m<sup>2</sup> basis). Segment I fertility studies in rats have shown oral doses up to 350 mg/kg/day (approximately equal to the maximum human daily dose on a mg/m<sup>2</sup> basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

##### **Pregnancy**

Pregnancy Category D: See **WARNINGS**.

## Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Consideration should be given to discontinuing nursing when valproic acid is administered to a nursing woman.

## Pediatric Use

Experience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). When valproic acid is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

Younger children, especially those receiving enzyme-inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproic acid concentrations.

The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding. The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m<sup>2</sup> basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m<sup>2</sup> basis.

## Geriatric Use

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor.

Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS - Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

## ADVERSE REACTIONS

### Other Patient Populations

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

#### Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. The administration of delayed-release divalproex sodium may result in reduction of gastrointestinal side effects in some patients.

#### CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes," dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and Parkinsonism have been reported with the use of valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

#### Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with

AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS - Drug Interactions**).

#### Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

#### Musculoskeletal

Weakness.

#### Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS - General and Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis, and acute intermittent porphyria.

#### Hepatic

Minor elevations of transaminases (e.g., SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

#### Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

#### Pancreatic

Acute pancreatitis, including fatalities (see **WARNINGS**).

#### Metabolic

Hyperammonemia (see **PRECAUTIONS**), hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

#### Genitourinary

Enuresis and urinary tract infection.

#### Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

#### Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever, and hypothermia.

### OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however, patients have recovered from valproate levels as high as 2120 mcg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdosage. Because naloxone could theoretically also reverse the antiepileptic effects of valproate, it should be used with caution in patients with epilepsy.

### DOSAGE AND ADMINISTRATION

THE CAPSULES SHOULD BE SWALLOWED WITHOUT CHEWING TO AVOID LOCAL IRRITATION OF THE MOUTH AND THROAT.

Valproic acid is administered orally. Valproic acid is indicated as monotherapy and adjunctive therapy in complex partial seizures in adults and pediatric patients down to the age of 10 years, and in simple and complex absence seizures. As the valproic acid dosage is titrated upward, concentrations of phenobarbital, carbamazepine, and/or phenytoin may be affected (see **PRECAUTIONS - Drug Interactions**).

### **Complex Partial Seizures**

For adults and children 10 years of age or older.

### **Monotherapy (Initial Therapy)**

Valproic acid has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 mcg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 mcg/mL in females and 135 mcg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

### **Conversion to Monotherapy**

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50-100 mcg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of valproic acid therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

### **Adjunctive Therapy**

Valproic acid may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 mcg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. If the total daily dose exceeds 250 mg, it should be given in divided doses.

Since valproate may interact with these or other concurrently administered AEDs as well as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

### **Simple and Complex Absence Seizures**

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day. If the total daily dose exceeds 250 mg, it should be given in divided doses.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 mcg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the valproic acid dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

The following Table is a guide for the initial daily dose of Valproic acid (15 mg/kg/day):

<b>Weight</b>		<b>Total Daily Dose</b>	<b>Number of Capsules</b>		
<b>(Kg)</b>	<b>(Lb)</b>		<b>Dose 1</b>	<b>Dose 2</b>	<b>Dose 3</b>
10-24.9	22-54.9	250	0	0	1
25-39.9	55-87.9	500	1	0	1
40-59.9	88-131.9	750	1	1	1
60-74.9	132-164.9	1,000	1	1	2
75-89.9	165-197.9	1,250	2	1	2

## General Dosing Advice

### Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

### Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of  $\geq 110$  mcg/mL (females) or  $\geq 135$  mcg/mL (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

### G.I. Irritation

Patients who experience G.I. irritation may benefit from administration of the drug with food or by slowly building up the dose from an initial low level.

## HOW SUPPLIED

Each white, oblong softgel (soft-gelatin capsule) imprinted PA2120, contains 250 mg valproic acid in bottles of 100's and 500's. The softgels should be protected from moisture and humidity and stored between 59-77°F (15-25°C) as per the container label. Dispense in a tight, light-resistant container as defined in the USP/NF.

Maalox® is a registered trademark of Novartis Consumer Health Canada Inc.

Titralac™ is a registered trademark of 3M.

## PATIENT INFORMATION LEAFLET

### Important Information for Women Who Could Become Pregnant About the Use of Valproic Acid Capsules.

Please read this leaflet carefully before you take this medication. This leaflet provides a summary of important information about taking this medication to women who could become pregnant. If you have any questions or concerns, or want more information about this medication, contact your doctor or pharmacist.

### Information For Women Who Could Become Pregnant

This medication can be obtained only by prescription from your doctor. The decision to use this medication is one that you and your doctor should make together, taking into account your individual needs and medical condition.

**Before using this medication, women who can become pregnant should consider the fact that this medication has been associated with birth defects, in particular, with spina bifida and other defects related to failure of the spinal canal to close normally. Approximately 1 to 2% of children born to women with epilepsy taking valproate in the first 12 weeks of pregnancy had these defects (based on data from Centers for Disease Control, a U.S. agency based in Atlanta). The incidence in the general population is 0.1 to 0.2%.**

This medication has also been associated with other birth defects such as defects of the heart, the bones, and other parts of the body. Information suggests that birth defects may be more likely to occur with this medication than some other drugs that treat your medical condition.

### Information For Women Who Are Planning to Get Pregnant

- Women taking this medication who are planning to get pregnant should discuss the treatment options with their doctor.

### Information For Women Who Become Pregnant

- If you become pregnant while taking this medication you should contact your doctor immediately.

### Other Important Information

- Your medication should be taken exactly as prescribed by your doctor to get the most benefit from your medication and reduce the risk of side effects.
- If you have taken more than the prescribed dose of your medication, contact your hospital emergency room or local poison center immediately.
- Your medication was prescribed for your particular condition. Do not use it for another condition or give the drug to others.

**Facts About Birth Defects**

It is important to know that birth defects may occur even in children of individuals not taking any medications or without any additional risk factors.

This summary provides important information about the use of valproic acid capsules to women who could become pregnant. If you would like more information about the other potential risks and benefits of these medications, ask your doctor or pharmacist to let you read the professional labeling and then discuss it with them. If you have any questions or concerns about taking this medication, you should discuss them with your doctor.

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